PRINTED: 07/21/2011 FORM APPROVED 391

ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00	COMPLETED				
	155712	D. WING	06/15/2011				

NAME OF PROVIDER OR SUPPLIER

NAME OF	PROVIDER OR SUPPLIER	1675 W	1675 W TIPTON ST				
COVER	ED BRIDGE HEALTH CAMPUS	SEYMO	DUR, IN47274				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0000							
	This visit was for the Recertification and State Licensure Survey. Survey dates: June 13, 14, and 15, 2011 Facility number: 003342 Provider number: 155712 AIM number: 200403740 Survey team: Melinda Lewis, RN TC Marla Potts, RN Sharon Whiteman, RN Census bed type: SNF: 19 SNF/NF: 37 Residential: 32 Total: 88 Census payor type: Medicare: 19 Medicaid: 24 Other: 45 Total: 88 Sample: 14 Residential sample: 8 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F0000	The submission of this Plan of Correction does not indicate an admission by Covered Bridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Covered Bridge Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZHT711

Facility ID:

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If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155712		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURVEY COMPLETED 06/15/2011			
		1557 12	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/15/2011
NAME OF P	PROVIDER OR SUPPLIER			TIPTON ST	
	D BRIDGE HEALTH		l l	DUR, IN47274	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	Ouality review co	ompleted 6/21/11 by			
	Jennie Bartelt, RN.				
F0157 SS=D	A facility must immresident; consult wand if known, notifice representative or a when there is an aresident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical alter treatment significant in a continue an exist of adverse consequence form of treatments.	nediately inform the vith the resident's physician; y the resident's legal an interested family member ccident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or s in either life threatening al complications); a need to inficantly (i.e., a need to sting form of treatment due uences, or to commence a nent); or a decision to ge the resident's legal resident's physician; and the complex commence a nent); or a decision to ge the resident from the			
	resident and, if known representative or in when there is a chassignment as spea change in reside State law or regular paragraph (b)(1) of the facility must re-	ecord and periodically			
	resident's legal rep family member. Based on intervie facility failed ens with the resident' received a faxed	es and phone number of the presentative or interested ew and record review, the sure timely follow up as physician to be sure he notification and request atment related to weight	F0157	F 157 Resident 33 suffered reffects from the alleged defining practice. Completion Date 7-13-2011 All other residents have the potential to be affected by the deficient practice and	cient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE COMPI	LETED	
		155712	B. WING	j		06/15/2	011
	PROVIDER OR SUPPLIER		•	1675 W	DDRESS, CITY, STATE, ZIP CODE TIPTON ST DUR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	loss for 1 of 5 resuming weight change in Resident # 33 Findings include The clinical recorreviewed on 6/13 record indicated diagnoses that in limited to chronic degeneration. The set assessment, Resident # 33 has cognition. Resident # 33 has cognition. Resident # 37 has cognition. Resident # 37 has cognition. Resident # 38 has cog	idents reviewed for a a sample of 14. In a sa		TAG	CROSS-REFERENCED TO THE APPROPR	sses timely pletion have g the ician emic view nge of our sician te vill ng eek for ults arterly	DATE
	order for Remero	elf. May we have an on (antidepressant) 7.5 edtime] for appetite					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155712	B. WIN			06/15/2011	
NAME OF F	DROLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1675 W	TIPTON ST		
	ED BRIDGE HEALTH				OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
	stimulant?"						
	1 *	er, dated 3/18/11 at 2:30					
	l '	"N.O. [new order]					
	_	P.O. [by mouth] QHS					
	appetite stimulan	t."					
	The nurses notes	lacked anv					
	documentation th	_					
		or phone between 3/10 to					
	1	physician order was					
	obtained.	physician order was					
	obtained.						
	B. A Weight Not	ification Form, dated					
		d, "4/17/11 169.8.					
	· ·	/3/11 171. Interventions:					
		Sugar free Mighty					
		times daily] Remeron					
	_	petite remains extremely					
	• • • • • • • • • • • • • • • • • • •	·					
	1 ^ *	refuses supplements. Res					
		ues to c/o pain "10" to					
	-	wer extremities].					
	1	[physical therapy] for					
	~ ~	nsfers. Is requiring 2 max					
	[maximum] assis	-					
		meron and start Megace					
		tite? Would you like any					
	pain meds ordere	ed? med list to follow"					
	C A Waight Na	tification Form dated					
	_	tification Form, dated					
		d, "4/24/11 165.8.					
		(10/11 170.4. 4/3/11 171.					
		cal 120 cc tid. Sugar free					
	Mighty Shakes B	BID [two times daily]					

003342

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		INSTRUCTION 00	(X3) DATE S COMPLE		
		155712	B. WING			06/15/20)11
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
COVERE	ED BRIDGE HEALTI	H CAMPUS		l	TIPTON ST DUR, IN47274		
		TATEMENT OF DEFICIENCIES			OIX, IN47274		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG			DATE
	Remeron 7.5 mg	Qhs. Appetite remains					
	extremely poor. Frequently refuses						
	supplements. Res	s [resident] continues to					
	_	BLE [bilateral lower					
		rently on PT [physical					
		ngthening/transfers. Is					
		[maximum] assist. Had 2					
	-	packed blood cells}					
	4/26/11 May we D/C [discontinue] Remeron and start Megace 400 mg for appetite? Would you like any pain meds						
	ordered? sending med list"						
	A Physician orde	er, dated 5/3/11, indicated,					
	1 -	nue] Remeron. 2. Megace					
	400 mg po QD [6	everyday]. 3. Tylenol 500					
	mg ii [two] po B	ID."					
	The nurses notes	lacked any					
		f the physician being					
		or phone between 4/20 to					
ı	1	hysician order was					
	obtained.						
	The Assistant Di	rector of Nursing					
	_	lity policy and procedure					
		ification guidelines,					
	l	n 6/14/11 at 11:30 A.M.					
		ated, "If the facility has					
	_	se to abnormal test results					
		ysician intervention					
		or notmal test results					
		the nurse on duty will					
	can the physician	to obtain further					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
1111212111	or conduction	155712	A. BUILDING B. WING		06/15/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN47274			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	- ,	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		empts to notify the				
		eir response should be				
		ne resident recordIf the				
		an does not respond to				
		npts after three phone Director and Director of				
		should be notified for				
	further instruction					
	of Nursing, on 6/ indicated Resider to get to respond	like to override other				
F0250 SS=D	social services to a highest practicable psychosocial well- Based on observa- record review, th Resident # 28 rec- assist with her an medicating the re- for 1 of 12 reside	esident for the anxiety,	F0250	F 250 Resident #28 suffered ill effects from the alleged deficient practice. Completion Date 7-13-2011 All residents have the potential to be affect by the alleged deficient pract and therefore through alterat in processes and in- servicing campus will ensure it provide medically-related social servito attain or maintain the highs	n ted ice ions g the s ces	

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155712	B. WIN	IG		06/15/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE		
				1	TIPTON ST		
COVERE	ED BRIDGE HEALTI	H CAMPUS		SEYMO	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	-			practicable physical, mental, psychosocial well-being of e		
					resident. Completion Date	acii	
	Resident #28 was	s identified by RN #1, the			7-13-2011 All campus staff	has	
	Assistant Directo	or of Nursing, on 6/13/11			been in serviced on need of		
	at 10:00 A.M., as	s cognitively impaired,			to notify social services. Car	npus	
	requiring a Hoye	er lift for transfers and			nurses have been in service		
		he resident was observed			using the new assessment to Mental Wellness Circumstan		
		e time of the tour.			Assessment and Intervention		
					form when a new or an	•	
	Resident #28's cl	inical record was			exacerbation of a behavior		
	reviewed on 6/14/11 at 10:00 A.M. The				occurs.Systemic change will		
		Data Set) assessment,			include completing the Ment		
	,	dicated the resident was			Health Wellness Circumstan Assessment, and Intervention		
	-				form when a new or an	111	
		rely impaired, with			exacerbation of a behavior		
		onsciousness constantly			occurs. Systemic change wil	l also	
	` .	epeatedly dozed off,			include SSD to review all ne	W	
		e), behaviors of (other			medication orders		
		ected towards other, e.g.			daily. Completion Date 7-13-2011 SSD and /or desi	anoo	
	_	g self, verbal/vocal			will print group behavior deta	-	
		these behaviors did not			report daily to assure the Me		
	impact the reside	ent or others.			Health Wellness Circumstan		
					Assessment, and Intervention	n	
	A Care Plan prob	olem, dated 3/11 and			form was completed when	o and	
	updated 6/7/11, i	ndicated, "mood, anxious			indicated to assure behavior psychosocial needs were	s and	
	appearance as ev	idenced by episodes of			documented, monitored, and	i	
	* *	anxiety medication in			addressed. Results of daily		
	•	history of anxiousness			audits will be forwarded mor	•	
	•	ment for resident."			to QA for 6 months and quar	terly	
		luded: "report to MD			thereafter for further suggestion/recommendation	e	
	changes in mood	_			based on	J	
	effectiveness of a				compliance. Completion Da	te	
					7-13-2011		
	ordered-see curre	ent physician orders."					
	Physician orders	dated 6/5/11, included					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155712		A. BUILDING 06/1			
		1007 12	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF I	PROVIDER OR SUPPLIER				/ TIPTON ST		
COVERE	ED BRIDGE HEALTH	H CAMPUS			DUR, IN47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN O			
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE)		DATE
	an order, which was started on admission 3/11/11, for "Alprazolam .25 mg, give one						
		be (gastrostomy tube)					
		needed for anxiety."					
	every o nours us	needed for univiery.					
	Medication Adm	inistration Records for					
	May 2011 and Ju	ine 1 to 13, 2011, and the					
	` '	Medication Tracking					
		the Alprazolam was					
	~	owing dates: 5/4/11 7:30					
		m., 5/6/11 7 p.m., 5/8/11					
	1	., 5/9/11 8 a.m. and 8					
	1 * *	.m., 5/12/11 7 p.m.,					
	_	/15/11 7 p.m., 5/21/11 11					
	_	.m. and 9 p.m., 6/3/11 11					
	* ·	m., and 6/13/11 7 a.m.					
		ntion Tracking Form					
		son given for each dose					
		ructions indicated "2"					
		ing, hand wringing, ons of anxiety, etc.).					
	There were three	-					
		ried before the medication					
		hree interventions were a					
		he following: "2-bedrest,					
		ocial service intervene,					
		5-position for comfort,					
	and 13-one on or	_					
	Nurses Notes dat	ed from 4/23 through					
	6/13/11, lacked a	ny documentation of					
	anxiety or what t	he resident was doing					
	prior to the admin	nistration of the					
	Alprazolam. Tł	ne Skilled Nursing					

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ANDILAN	OF CORRECTION	155712	- 1	A. BUILDING 00			06/15/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2		
NAME OF I	PROVIDER OR SUPPLIER				/ TIPTON ST			
COVERE	ED BRIDGE HEALTH	H CAMPUS		1	DUR, IN47274			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
IAG		Data Collection Forms,	-	IAU			DATE	
		1 through 6/13/11, did						
	1	locumentation under the						
	1	od and behavior, check						
		Areas to check included,						
	1 11 1	ted to: "trouble falling or						
	staying asleep, fi	•						
	1	or interfere with social						
	_	upt environment, resident						
	rejects care"	,						
	The Social Service Progress Notes,							
	included entries	dated 3/12/11 and 5/4/11.						
	The 3/12/11 entry	y included: "resident						
	takes Alprazolam	1.25 mg every 6 hours						
	prn (as needed) f	or anxiety." The 5/4/11						
	entry indicated th	ne resident was adjusting						
	to new room and	"res voices no concerns						
	and says yes to b	eing pleased with new						
	room." There we	ere no notes concerning						
	the resident's being	ng anxious.						
		with RN #1 on 6/14/11						
	1	ne indicated the facility						
		book for residents with						
		dicated Resident #28						
		in the book, and that						
		eated the plans in the						
	book.							
	During interview	with the Social Service						
	-	11 at 10:05 A.M., she						
	indicated the resi	dent did not currently						
	have anxiety. Sh	e indicated she was not						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 06/15/2	LETED
	PROVIDER OR SUPPLIER		STREET A 1675 W	DDRESS, CITY, STATE, ZIP COD TIPTON ST OUR, IN47274	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	aware staff were Alprazolam or w symptoms were.	giving the as needed hat the resident's				
	at 1:15 p.m., she evening shift and Alprazolam seve She indicated the her call light seven her communication unable to figure wanted. She indiresident was much	with LPN #3 on 6/14/11 indicated she worked had administered the ral times in May 2011. The resident was restless, on eral times, would not use on board and staff were out what the resident icated she felt the enable better at this time, and in the drug since mid May.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155712	B. WING	NG .		- 06/15/2011	
				TREET AT	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				TIPTON ST		
COVERE	D BRIDGE HEALTH	H CAMPUS			JR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
F0279	A facility must use						
SS=D		velop, review and revise the					
	resident's comprei	nensive plan of care.					
	The facility must d	evelop a comprehensive					
	-	resident that includes					
		tives and timetables to meet					
	•	al, nursing, and mental and					
	psychosocial need	ls that are identified in the					
	comprehensive as	sessment.					
	The same alone access						
The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,							
		osocial well-being as					
		83.25; and any services that					
	would otherwise b	e required under §483.25					
	•	ed due to the resident's					
		under §483.10, including the					
	-	tment under §483.10(b)(4).	F005	,	F 270		07/10/0011
		ew and record review, the	F0279	9	F 279		07/13/2011
	-	develop an individualized			Resident #28's care plans have l	neen	
	•	sident #28 with increased			reviewed and updated as applica		
	, .	n-pharmacological			The second secon		
	interventions bas	ed on the resident's			Completion Date 7-13-2011		
	symptoms, for 1	of 12 residents reviewed					
		n the sample of 14.			All residents have the potential		
	Resident #28	1			affected by the alleged deficient		
					practice therefore through system		
	Findings include				changes stated below the campu ensure the resident's plan of car		
	rindings include	•			current.	e is	
	D :1 ://20	·1 11 D31 4			Completion Date 7-13-2011		
		s identified by RN #1, the			Completion Date / 10 Bull		
		or of Nursing, on 6/13/11					
	at 10:00 A.M., as	s cognitively impaired,					
	requiring a Hoye	er lift for transfers and			An in-service was provided to		
	being bedfast. T	he resident was observed			nursing staff concerning		
	-	e time of the tour.			non-pharmacological intervention		
	<i>j E</i>				for residents with behaviors and	care	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155712		LDING	00	06/15/2	
		1007 12	B. WIN		DDDEGG CITY OTHER TIN CODE	00/10/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE 'TIPTON ST		
COVERE	ED BRIDGE HEALT	H CAMPUS		1	DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE	DATE
	reviewed on 6/14 MDS (Minimum dated 3/18/11, in severely cognitive altered level of cognitive difficult to aroust behaviors not dishitting, scratching	linical record was 4/11 at 10:00 A.M. The a Data Set) assessment, adicated the resident was vely impaired, with consciousness constantly, repeatedly dozed off, ae), behaviors of (other rected towards other, e.g. ag self, verbal/vocal these behaviors did not ent or others.			plans. Systemic change is a cop the care plan for residents with behaviors will be kept in the from the resident's specific medication administration sheet. Completion Date 7-13-2011 DHS/designee will perform and 2 random residents with behavious assure care plans are current and place 5x week x one month then weekly results forwarded to QA commitmentally x 6 months and quarter thereafter for review and further suggestions/comments	active ont of on lits of ors to d in 1 3x a with ttee	
	1	blem, dated 3/11 and			Completion Date 7-13-2011		
	_	indicated, "mood, anxious					
	1 ^ ^	videnced by episodes of anxiety medication in					
		history of anxiousness					
	1 ~	ment for resident."					
		cluded: "report to MD					
	changes in mood	-					
	effectiveness of						
		ent physician orders."					
	Physician orders	, dated 6/5/11, included					
	· ·	was started on admission					
	1	orazolam .25 mg give one					
		astrostomy] tube every 6					
	hours as needed	for anxiety."					
	Medication Adm	ninistration Records for					
	May and June 1	to 13, 2011 and the PRN					
	I -	king Forms indicated the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712		(X2) MUL A. BUILD B. WING		OO	(X3) DATE S COMPL 06/15/20	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u>'</u>		DDRESS, CITY, STATE, ZIP CODE		
COVERE	ED BRIDGE HEALT	H CAMPUS			TIPTON ST JR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\top	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG	Alprazolam was dates: 5/4/11 7:3 5/6/11 7 p.m., 5/5/9/11 8 a.m. and 5/12/11 7 p.m., 5/9.m., 5/21/11 11 p.m., 6/3/11 11 p.m., 6/3/11 11 p.m., 6/3/11 11 p.m. for each dose was indicated "2" was wringing, rocking etc.). There were documented as the was given. The the combination of the 5-diversion, 10-8 14-reassurance, 13-one on one time. Nurses Notes date 6/13/11 lacked a anxiety or what is prior to the admit Alprazolam. The Assessment and dated 5/9/11 dail not include any of the box labeled mooth that apply. Area were not limited staying asleep, filethargic, behavior and the staying asleep.	given on the following 0 p.m., 5/5/11 7 p.m., 8/11 8 a.m. and 6 p.m., d 8 p.m., 5/11/11 7 p.m., 5/14/11 7 p.m., 5/15/11 7 p.m., 5/23/11 1 a.m. 9 p.m., 6/5/11 1 a.m., The PRN Medication Indicated the reason given as "2." The instructions as anxiety (pacing, hand g, expressions of anxiety, the three interventions ried before the medication hree interventions were a the following: "2-bedrest, social service intervene, 15-position for comfort, me." Ited from 4/23 through my documentation of the resident was doing mistration of the the Skilled Nursing Data Collection Forms y through 6/13/11, did documentation under the d and behavior, check all as to check included but to: "trouble falling or		- 1	CROSS-REPERIOLED TO THE APPROPRIAT DEFICIENCY)	E	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY IPLETED 5/2011	
	PROVIDER OR SUPPLIER		STREET 1675 V	ADDRESS, CITY, STATE, ZIP V TIPTON ST OUR, IN47274	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
0	rejects care"	200 122 111.0 111.01111111111111111				5.112
	included entries of The 3/12/11 entry takes Alprazolam prn (as needed) from the entry indicated the tonew room and and says yes to broom." There we the resident's being the properties of the properties of the entry indicated the resident's being the properties of	with RN #1 on 6/14/11 ne indicated the facility book for residents with indicated Resident #28 in the book, and that reated the plans in the with the Social Service //11 at 10:05 A.M. she dent did not currently he indicated she was not giving the as needed				
	6/14/11 at 1:15 p worked evening	with LPN #3, on .m., she indicated she shift and had alprazolam several times				
		ne indicated the resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155712	A. BUILDING B. WING		06/15/2011		
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
COVERE	D BRIDGE HEALTI	H CAMPUS	1675 W TIPTON ST SEYMOUR, IN47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	times, would not board and staff w what the resident she felt the resident this time and she since mid May. 3.1-35(b)(1)	ner call light several use her communication were unable to figure out wanted. She indicated ent was much better at had not given the drug					
F0323 SS=E	environment rema hazards as is poss receives adequate devices to prevent Based on observa- record review, th residents with a l staff supervision responded to in t alternate interver when alarms fail- the planned inter- were implements	ation, interview, and e facility failed to ensure history of falls received to ensure alarms were hime to prevent falls, hitions were implemented ed to prevent falls, and ventions to prevent falls ed for 4 of 8 residents is in a sample of 14.	F0323	F 323 Resident #'s 23,26,33, and 39 p care related to risk for falls has reviewed and updated as necess and staff has been in- serviced or plan of care. Completion Date 7-13-2011 All other residents are at risk to affected by the alleged deficient and through alterations in proce and in-servicing the campus will ensure that the resident environment remains as free of accident haza	been ary on this be cy sses Il ment		

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Event ID: ZHT711

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li '		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155712	B. WIN	G		06/15/2	011
NAME OF I	PROVIDER OR SUPPLIER	3	•	1	ADDRESS, CITY, STATE, ZIP CODE		
				1	TIPTON ST		
COVERE	ED BRIDGE HEALT	H CAMPUS		SEYMO	DUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
					as is possible; and each resident receives adequate supervision a		
	Findings include	::			assistance devices to prevent	IIU	
					accidents.		
	1. During intervi	iew on the initial tour on			Completion Date 7-13-2011		
		A.M., the Director of					
	Nursing indicate	ed Resident # 26 was not				. ,	
	interviewable an	d had recent fall.			Nursing staff have been in-serv concerning Fall/Safety Manage		
	Resident # 26 wa	as observed at the time to			Systemic change is the C.N.A.	ment.	
	be in a bedside r	ecliner asleep.			Assignment sheet that commun	icates	
					to the C.N.A. fall and safety		
	On 6/13/11 at 1:	35 P.M., Resident # 26			interventions will be updated af		
	was observed to	be asleep in a bedside			IDT reviews 5x week, and a new	W	
	recliner in her ro	oom. Resident # 26's			intervention is put in place.		
	wheelchair was	observed to be sitting in			Completion Date 7-13-2011		
	front of the resid						
					DHS /designee will monitor 3		
	On 6/13/11 at 2:	50 P.M., Resident # 26			random resident at risk for falls		
		be asleep in a bedside			assure safety interventions in pl		
		oom. Resident # 26's			per plan of care and staff follow plan of care to prevent an accid-		
		observed to be sitting in			a week for a month then 3x a w		
	front of the resid	•			for a month then weekly with re		
	l Hont of the resid	ient.			forwarded to QA committee mo		
	On 6/13/11 at 4.	30 P.M., Resident # 26			x 6 months and quarterly therea	fter	
		be asleep in a bedside			for review and further		
		oom. Resident # 26's			suggestions/comments Completion Date 7-13-2011		
					Completion Date /-13-2011		
	front of the resid	observed to be sitting in					
	noncor the resid	CIII.					
	On 6/14/11 at 9.	40 A.M., Resident # 26					
	was observed to						
	wheelchair in the	-					
	wincerenan in the	o nanway.					
	The clinical room	ord for Resident # 26 was					
		3/11 at 3:20 P.M. The					
	reviewed on 6/1.	3/11 at 3.20 P.IVI. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155712	B. WIN			06/15/2011	
NAME OF I	DROVIDED OD GUDDI IED		!		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1675 W	TIPTON ST		
	ED BRIDGE HEALTI				OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		.ON
TAG	 	· · · · · · · · · · · · · · · · · · ·	+	TAG	DETICIENC!)	DATE	
		Resident # 26 had					
	_	cluded but were not					
		tia. The MDS [Minimum					
	I -	nent, dated 4/8/11,					
		nt # 26 had severely					
	1 ^ ~	on. Resident # 26					
	1 *	ve assistance of one with					
	bed mobility, ext	tensive assistance of two					
	with transfers and	d toilet use and did not					
	ambulate. Reside	ent # 26 had fallen since					
	the previous asse	essment one fall with					
	injury and one fa	ll resulted in major					
	injury.						
	The Nurses Note	es, dated 2/23/11 at 10:45					
		"Res [resident] found by					
		loor on R [right] side of					
	1	st back to w/c. Res claims					
	1 *	go to restroom. Various					
	1	n floor, inadequate					
		at within reach but not					
	1 0 0	t have glasses on. No					
	footwearRes of						
		ry] 2 hours to decrease					
	1						
	chances of falling	g agam					
	A Fall Circumsta	ince Assessment and					
		ed 2/23/11, indicated,					
		odate- Started neuro					
	_	ly used items within					
	_	hours assist, Adequate					
	lighting, glasses	_					
		Team] Review- IDT					
	1	-					
	I review of above	prevention update agrees					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	LETED
		155712	B. WIN			06/15/2	011
NAME OF I	DROLUDED OD GLIDDLIEF		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIEF	C		1675 W	TIPTON ST		
	ED BRIDGE HEALT				OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAU		LSC IDENTIFYING INFORMATION)	-	TAG	Barelakery		DATE
	1	maximize safety- N [no].					
		2-24-11. IDT review					
		following change to					
	1	te: Toilet Q 2 hours at					
	night"						
	The Name of N	4-4-10/04/11 10/00					
		es, dated 2/24/11 at 10:20					
	1 ' '	"CNA alerted writer and					
		es doorway. Res was					
		at to her w/c on her					
		nst the wall. Res had just					
		y the CNA propelling self					
	1	and looking around as					
	_	to enter neighboring					
		a thump sound exited the					
		resident. Res exhibiting					
	increased confus	sion and drowsiness in					
	general typical s	x [symptoms] for her					
	when she has a U	JTI [urinary tract					
	infection] and re	s is currently receing (sic)					
	po [by mouth] A	tb [antibiotic] to treat					
	such. Res alert a	nswers questions					
	appropriatelyR	tes denies pain 2 staff					
	assisted res up a	nd into her w/c. Res bears					
	_	well without obvious					
		Res assisted to restroom					
		.Call light at side within					
		es staff she will call for					
	assist before get						
		- O-T					
	A Fall Circumsta	ance Assessment and					
	Intervention, dat	red 2/24/11, indicated,					
	"Prevention U						
		ilet Q 2 hours assist/cues,					
							L

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MU A. BUILI		NSTRUCTION 00	(X3) DATE S COMPL		
		155712	B. WING			06/15/2	011
NAME OF I	PROVIDER OR SUPPLIEI	" }	' I	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					TIPTON ST		
COVERE	ED BRIDGE HEALT	H CAMPUS		SEYMO	DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAU	•	ng, glasses in place, teach		IAG			DATE
	1 ^ ~	[Interdisciplinary Team]					
	1	view of above prevention					
		appropriate to maximize					
		Date of review 2-25-11.					
	1	mmends the following					
		ntion update: Will request					
	1	ture and sensitivity]					
	1	stablish sleep pattern"					
	The Nurses Note	es, dated 3/27/11 at 2:00					
	A.M., indicated,	"Writer answered call					
	light entered the	room and found res					
	sitting on her bu	ttocks with her legs					
	extended toward	s her roommates HOB					
	[head of bed]. R	es states she fell out of					
	1	she knows she hit her					
		it was on the floor but she					
		oted to have a 4 x [by] 2					
	1 1	rple hematoma on her R					
	1	extending up into the					
	1	[complains of] mild pain					
		t/ankle. Res states it is					
	1 ^	palpated mild purple served in the L [left]					
	1	region. Res assisted to sistance then to bed and					
	ice pack applied						
	hematoma"	to K foreneau					
	The Nurses Note	es, dated 3/27/11 at 2:30					
		"Dr (name) notified via					
	1 '	escribed MD stated					
		ht and see how she is in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		A. BUILDIN		NSTRUCTION 00	(X3) DATE: COMPL 06/15/2	ETED	
	PROVIDER OR SUPPLIER		10	675 W	DDRESS, CITY, STATE, ZIP CODE TIPTON ST UR, IN47274	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	the morning." The Nurses Note A.M., indicated, writer that she w on r/t [related to] assessment to L bruising measuri c/o pain with any is swollen. Dr (n order] rec'd [rece foot/ankle" The Nurses Note P.M., indicated, receivedLt [lef [and] 5th metatat fractures" A Fall Circumsta Intervention, dat	s, dated 3/27/11 at 8:30 "CNA reported to this as un able to put res shoe swelling/pain. Upon foot with bluish/purple ng 6.0 cm x 5.0 cm. Res y movement/touch. Area ame) notified N.O. [new cived] for x-ray L s, dated 3/27/11 at 2:10 "Xray results t] foot xray shows 4th et real [toes] neck ance Assessment and ed 3/27/11, indicated,	TA	AG			DATE
	facility policy, g alarm. IDT [Inter Review- IDT rev update agrees as safety- Y [yes]. I IDT review recordings to preven hours at night" The Nurses Note A.M., indicated,	date- neuro checks per lasses in place, sensor rdisciplinary Team] riew of above prevention appropriate to maximize Date of review 3/28/11. Immends the following ration update: Toilet Q 2 s, dated 4/15/11 at 1:30 "Res calling out help om at 12:30 am, bed					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE COMPI		
ANDILAN	or connection	155712	A. BUII			06/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				TIPTON ST		
COVERE	ED BRIDGE HEALTH	H CAMPUS		1	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
IAG			-	IAG	BEFFELEXICTY		DATE
	·	writer and CNA were oom Res lying in floor					
		r left side. Res states I					
		getting up to answer the					
	_	small R [red] area on L					
	_	ise 2 cm x 1 cm on R					
	· ·	n tear on left lower leg					
		nately] 1.5 cmRes was					
		[two] assist and taken to					
	· •	observationRes sat at					
		1 hour then asked to go					
		assisted to bed by writer.					
		d functioning call light					
		res educated to use call					
	light. Res states s	sometimes I can't see it					
	_	d to res blankets and res					
	_	ght at this x [time]."					
	The Nurses Note	s, dated 4/15/11 at 8:00					
		"Intervention for fall:					
	l '	v in the dark call light"					
	low sea and grov	v in the dark can right					
	A Fall Circumsta	nce Assessment and					
	Intervention, date	ed 4/15/11, indicated,					
	"Prevention Up	odate- neuro checks per					
	protocol, alarmin	ng bed mat. IDT					
	[Interdisciplinary	Team] Review- IDT					
	review of above	prevention update agrees					
		maximize safety- N [no].					
	Date of review 4	/15/11. IDT review					
	recommends the	following change to					
		e: Res will be placed in a					
		en glow in the dark call					
	light"						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155712	B. WIN			06/15/2011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR SOLVER			1	TIPTON ST		
COVERE	ED BRIDGE HEALTH	H CAMPUS		SEYMO	DUR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E.	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DA	TE
		s, dated 4/28/11 at 3:00					
	l ' '	"Writer informed of Res					
	on floor by CNA	. upon entering res rm					
	CNA et [and] RN	Valready present. Res					
	found lying with	feet in bed et head in					
	recliner sliding o	nto floor. CNA reports					
	res lying on back	with pillow behind head					
	in floor. Res was	2 staff assist back into					
	bed. No injury of	oserved at this time.					
	Denies painRes	s cannot verbalize to staff					
	_	fellall safety devices in					
		ing at time of fall"					
	1						
	A Fall Circumsta	nce Assessment and					
		ed 4/28/11, indicated,					
	· ·	odate-neuro checks per					
	1	close to nursing station,					
	^	on, 2 hour safety checks,					
	_	t toileting, staff inservice					
		n low position. IDT					
		Team] Review- IDT					
	1 '	-					
	·	prevention update agrees					
		maximize safety- N [no].					
		/28/11. IDT review					
		following change to					
		e: moved closer to nurses					
	desk. staff educat						
	positioning of lo						
	[discontinue] 2 h	our safety checks"					
	_	ded by the Director of					
	•	/11 at 8:45 A.M.,					
	indicated the fam	nily refused the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/15/2	ETED	
		1007.12	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF	PROVIDER OR SUPPLIEF	R			TIPTON ST		
	ED BRIDGE HEALT			SEYMO	UR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
0	+	esident to be moved closer					D.H.E
	to the nurses stat						
	The Nurses Note	es, dated 6/10/11 at 9:20					
		"Res noted on floor					
	1 ' '	and wheelchair. Res was					
	transferring self	from recliner to w/c. Res					
	1	isible injuriesAlarm					
	placed in recline	r"					
	1	iew on the initial tour on					
		A.M., the Director of					
	1 -	ed Resident # 23 was not					
	interviewable an	d had a recent fall.					
	On 6/13/11 at 1:	35 P.M., Resident # 23					
	was observed to	be in a low bed asleep. A					
	mat was observe	ed to be next to the bed.					
	On 6/13/11 at 2:	50 P.M., Resident # 23					
		be in a low bed asleep. A					
	mat was observe	ed to be next to the bed.					
	On 6/13/11 at 4:	30 P.M., Resident # 23					
	1	be up in a wheelchair.					
		as observed to be					
	participating in a	an activity.					
		ord for Resident # 23 was					
		3/11 at 10:00 A.M. The					
		Resident # 23 had					
	~	cluded but were not					
		nson's disease and					
	dementia. The M	IDS [Minimum Data Set]					

NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES SEYMOUR, IN47274 (X6) ID REDIT (LEACH DEFICENCY MUST BE PERCEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Assessment, dated 4/10/11, indicated Resident # 23 had moderately impaired cognition. Resident # 23 required extensive assistance of two with bed mobility, transfers, and toilet use. Resident # 23 had fallen since the previous assessment. A Care plan, dated 1/12/11 and updated on 4/14/11, indicated a problem of "At risk for fall/injury AEB [as evidenced by] history of falls, potential for fall R/T [related to] disease process/condition: Parkinsons, dementia, seizure disorder, decreased mobility rt Parkinsons, Ativan (antianxiety medication) PRN [as needed] Trazadone (antidepressant medication), Use of assistice (sic) devices: high back w/c." The interventions included but were not limited to "Call light within reach, Defined parameter mattress, Referral for screen and treatment as needed." The Nurses Notes, dated 1/21/11 at 10:30 P.M., indicated, "Rd [resident] slipped off side of bed denies hitting head and denies pain. No visible injuries at this time" A Fall Circumstance, Assessment and Intervention, dated 1/21/11, indicated, "Prevention Updated-Toilet q2h [every	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		(X2) MU A. BUIL B. WING	DING	nstruction 00	(X3) DATE S COMPL 06/15/20	ETED	
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG ASSESSMENT, dated 4/10/11, indicated Resident # 23 had moderately impaired cognition, Resident # 23 required extensive assistance of two with bed mobility, transfers, and toilet use. Resident # 23 did not ambulate. Resident # 23 had fallen since the previous assessment. A Care plan, dated 1/12/11 and updated on 4/14/11, indicated a problem of "At risk for fall/injury AEB [as evidenced by] history of falls, potential for fall R/T [related to] disease process/condition: Parkinsons, dementia, seizure disorder, decreased mobility r/t Parkinsons, Ativan (antianxiety medication) PRN [as needed] Trazadone (antidepressant medication), Use of assistice (sic) devices: high back w/c." The interventions included but were not limited to "Call light within reach, Defined parameter mattress, Referral for screen and treatment as needed." The Nurses Notes, dated 1/21/11 at 10:30 P.M., indicated, "Rd [resident] slipped off side of bed denies hitting head and denies pain. No visible injuries at this time" A Fall Circumstance, Assessment and Intervention, dated 1/21/11, indicated, "Prevention Updated-Toilet q2h [every					STREET A	TIPTON ST		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) ASSESSMENT, dated 4/10/11, indicated Resident # 23 had moderately impaired cognition. Resident # 23 required extensive assistance of two with bed mobility, transfers, and toilet use. Resident # 23 did not ambulate. Resident # 23 had fallen since the previous assessment. A Care plan, dated 1/12/11 and updated on 4/14/11, indicated a problem of "At risk for fall/injury AEB [as evidenced by] history of falls, potential for fall R/T [related to] disease process/condition: Parkinsons, dementia, seizure disorder, decreased mobility rf Parkinsons, Ativan (antianxiety medication) PRN [as needed] Trazadone (antidepressant medication), Use of assistice (sic) devices: high back w/c." The interventions included but were not limited to "Call light within reach, Defined parameter mattress, Referral for screen and treatment as needed." The Nurses Notes, dated 1/21/11 at 10:30 P.M., indicated, "Rd [resident] slipped off side of bed denies hitting head and denies pain. No visible injuries at this time" A Fall Circumstance, Assessment and Intervention, dated 1/21/11, indicated, "Prevention Updated-Toilet q2h [every	COVERE	ED BRIDGE HEALTI	H CAMPUS		SEYMO	UR, IN47274		
Resident # 23 had moderately impaired cognition. Resident # 23 required extensive assistance of two with bed mobility, transfers, and toilet use. Resident # 23 did not ambulate. Resident # 23 had fallen since the previous assessment. A Care plan, dated 1/12/11 and updated on 4/14/11, indicated a problem of "At risk for fall/injury AEB [as evidenced by] history of falls, potential for fall R/T [related to] disease process/condition: Parkinsons, dementia, seizure disorder, decreased mobility r/t Parkinsons, Ativan (antianxiety medication) PRN [as needed] Trazadone (antidepressant medication), Use of assistice (sic) devices: high back w/c." The interventions included but were not limited to "Call light within reach, Defined parameter mattress, Referral for screen and treatment as needed." The Nurses Notes, dated 1/21/11 at 10:30 P.M., indicated, "Rd [resident] slipped off side of bed denies hitting head and denies pain. No visible injuries at this time" A Fall Circumstance, Assessment and Intervention, dated 1/21/11, indicated, "Prevention Updated-Toilet q2h [every	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſΕ	(X5) COMPLETION DATE
Intervention, dated 1/21/11, indicated, "Prevention Updated- Toilet q2h [every	TAG	assessment, date Resident # 23 ha cognition. Reside extensive assista mobility, transfe Resident # 23 die # 23 had fallen s assessment. A Care plan, date on 4/14/11, indic risk for fall/injur history of falls, p [related to] disea Parkinsons, dem decreased mobili (antianxiety med Trazadone (antid Use of assistice (w/c." The interve not limited to "C Defined paramet screen and treatm The Nurses Note P.M., indicated, side of bed denie pain. No visible	d 4/10/11, indicated d moderately impaired ent # 23 required nce of two with bed rs, and toilet use. d not ambulate. Resident ince the previous ed 1/12/11 and updated rated a problem of "At y AEB [as evidenced by] rotential for fall R/T se process/condition: entia, seizure disorder, retry r/t Parkinsons, Ativan ication) PRN [as needed] repressant medication), resic devices: high back rentions included but were all light within reach, remattress, Referral for ment as needed." es, dated 1/21/11 at 10:30 "Rd [resident] slipped off resident] slipped off resident at this time"		TAG	DEFICIENCY)		DATE
two hours]IDT [Interdisciplinary Team] Review- IDT review of above prevention		Intervention, dat "Prevention Up two hours]IDT	ed 1/21/11, indicated, odated- Toilet q2h [every [Interdisciplinary Team]					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZHT711

Facility ID:

003342

If continuation sheet Page 24 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	INSTRUCTION	(X3) DATE S COMPL		
AND PLAN	and Plan of Correction identification number: 155712		A. BUII		00	06/15/2	
		1007 12	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF I	PROVIDER OR SUPPLIER				TIPTON ST		
COVERE	ED BRIDGE HEALTI	H CAMPUS			DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	DEFICIENCE!)		DATE
	safety- Y [yes]. I	appropriate to maximize					
	safety- 1 [yes]. 1 1-24-11"	Jaic of Teview-					
	1-24-11						
	The fall care plan, dated 1/12/11, was updated on 1/21/11 to include the intervention of "Toilet Q 2 h[every two						
	hours] at noc [nis						
	nours at not [mg	5110].					
	A Falls Screen d	lated 1/24/11, indicated,					
	"Identification						
	FactorsResident is incontinent of						
		Resident is confused.					
		tedw/c only doesn't self					
		nber] of falls in last 3					
	^ ^ ~	tion of falls bedroom.					
	Environmental/si						
	informationmo	st falls occur when pt					
	[patient] needs to	_					
	• •	nsfer out of bed without					
	assist"						
	The Nurses Note	s, dated 4/21/11 at 9:00					
	P.M., indicated,	"Res [resident] found on					
	floor beside bed.	Res asking for wife					
	alarm on and in p	place, not sounding no					
	visible injuries n	otedAlarm placed and					
	tested for function	n alarm is working					
	properly"						
	A Fall Circumstance, Assessment and						
	Intervention, dated 4/21/11, indicated,						
	· ·	odated- Med [medication]					
		S [urinalysis culture and					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	TED
		155712	B. WIN			06/15/201	11
NAME OF I	DROVADED OD GLIDDI IED		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF E	PROVIDER OR SUPPLIER			1675 W	TIPTON ST		
	ED BRIDGE HEALTI				OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	.	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE)		DATE
	sensitivity], if or						
	1 * * *	Team] Review- IDT					
		prevention update agrees					
		maximize safety- Y					
	[yes]. Date of review- 4/22/11. IDT review recommends the following change to prevention update: alarm box/pad						
	replaced"						
	The fall care plan	n, dated 1/12/11, was					
	updated on 4/21/	11 to include the					
	1 -	UA C & S [urinalysis					
		tivity], Med [medication]					
	review, alarm bo	• • •					
	Teview, unum oc	sa pud repluced.					
	The Nurses Note	s dated 4/25/11 at 1110					
	l ` ' ' '						
	_	_					
	safety unless in b	bed of whe present"					
	A Fall Circumsta	ince, Assessment and					
		·					
	1 *	•					
	1 -						
	Review- IDT review of above prevention						
	update agrees as appropriate to maximize						
	safety- Y [yes]. Date of review-						
	4/26/11"						
	The fall care plan	n, dated 1/12/11. was					
	(11:10 A.M.), ind found res lying of w/c. Denies patheadAssisted be Will leave res at safety unless in the A Fall Circumsta Intervention, date "Prevention Up [nurses station] to presentIDT [In Review- IDT revupdate agrees as safety- Y [yes]. In 4/26/11"	appropriate to maximize					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE SU COMPLE	
11112 12111	or columberion	155712	A. BUII B. WIN			06/15/20	
NAME OF E	PROVIDER OR SUPPLIER		D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
					TIPTON ST		
	D BRIDGE HEALTH				DUR, IN47274		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	updated on 4/25/						
		Keep at nurses station					
	unless in bed or v	with wife."					
	The Nurses Note	es, dated 5/1/11 at 9:00					
	P.M., indicated, "At 6:45 pm rd [resident] found on floor lying on left side. Rd denies hitting headhe was trying to						
		ter asked rd roommate if					
		o room and left rd					
	unattended, rd roommate states "yes he asked to go into the room so I helped"						
	_	roommate about rd					
	needing to be at 1	nurses station unless wife					
	is present"						
	A Fall Circumsta	ince, Assessment and					
		ed 5/1/11, indicated,					
		odated- roommate					
	educationIDT [[Interdisciplinary Team]					
		riew of above prevention					
		appropriate to maximize					
	safety- Y [yes]. I 	Date of review- 5/2/11"					
	The fall care plar	n, dated 1/12/11, was					
	updated on 5/1/1						
		Roommate education on					
		lent into room and					
	leaving him alon	e due to safety."					
	The fall care plan	n, dated 1/12/11, was					
	updated on 5/5/1						
	intervention of "l						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		(X2) M A. BUII		NSTRUCTION 00	COM	TE SURVEY MPLETED	
		155712	B. WIN			06/1	5/2011
	PROVIDER OR SUPPLIER		•	1675 W	DDRESS, CITY, STATE, ZIP (TIPTON ST	CODE	
	D BRIDGE HEALTH			<u> </u>	OUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	The Nurses Note A.M., indicated, sounded, CNA refloor. Writer call observed on floor mat. 2 staff assist states he was tryi incont [incontine bowel/bladder) [left] knee slightly changed res et [a get out of bed. Be station] with writer reach, floor alarm Res to be offered states he wants to at this time with the thing that the states he wants to at this time with the fall care plan updated on 6/12/interventions of '[night] and Spok [related to] wife week. Reassured the best care possiname)." 3. On the initial to A.M., the Director Resident # 33 was had no recent fall.	s, dated 6/12/11 at 4:30 "Res floor alarm eports res on knees in ed to rm [room]. Res r beside bed knees on t res back to bed. Res ing to go to restroom (Res int] denies pain/distress L ly red from floorStaff ind] res continues to try to rought res to ns [nurses ter. Call light within in in place et functioning. I urinal at night since he o use restroom. Res at NS writer eating yogurt" in, dated 1/12/11, was 11 to include the "Offer urinal at noc e with res [resident] r/t ino being here this past res that wife is receiving sible while at (hospital) our, on 6/13/11 at 9:30 or of Nursing indicated as not interviewable and					
	,, as 50501 ved 10	oo iii a wiioolollalii oltaliig		ļ			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155712	A. BUII B. WIN			06/15/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	Į	
NAME OF I	PROVIDER OR SUPPLIER			1675 W	TIPTON ST		
COVERE	ED BRIDGE HEALTH	H CAMPUS		SEYMO	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG	at the dining room	· · · · · · · · · · · · · · · · · · ·	+	IAU			DATE
	at the uning roof	iii tauic.					
	On 6/13/11 at 1·3	35 P.M., Resident # 33					
		be in a bedside recliner					
	asleep.						
	On 6/13/11 at 2:2	20 P.M., Resident # 33					
	was observed to	be in a bedside recliner					
	asleep.						
	On 6/13/11 at 4:30 P.M., Resident # 33 was observed to be up in a wheelchair						
	sitting in the hall	way.					
		rd for Resident # 33 was					
		3/11 at 10:45 A.M. The					
		Resident # 33 has					
	I -	cluded, but were not					
	· ·	ic anemia and macular					
	~	e MDS [Minimum Data					
	_	dated 3/24/11, indicated					
		d moderately impaired					
	cognition. Reside	•					
	1 ^	ne with bed mobility and nt # 33 had fallen since					
	the previous asse						
	the previous asse	SSIIICIII.					
	A Care nlan date	ed 3/25/11 and updated					
	· -	ted a problem of "Falls					
	l '	jury AEB [as evidenced					
	l '	ls, Potential for falls R/T					
	• •	se process/condition:					
	blindness d/t [du	-					
	-	ib [atrial fibrillation],					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIEF		•	1675 W	ADDRESS, CITY, STATE, ZIP CODE TIPTON ST OUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	dependent diabe usage: antidepre (sic) devices: w/included but werenvironmental activater, call light resident and rein Lock breaks (sic transferring." The Nurses Note P.M., indicated, next to wheelchat trying to get into got weak. No inj [complaints of] protified. Resider help when transfer help when transfer. A Fall Circumstatintervention, dat "Prevention Uphelp to transfer. Team] review- In prevention updat maximize safety 4/8/11, IDT reviet following chang in w/c between encouraged to got	ion], NIDDM [noninsulin tes mellitus], medication sants, use of assistice c." The interventions is not limited to "Provide daptations: area free of within reach. Remind force safety awareness." on bed, chair, etc before its, dated 4/7/11 at 5:30 "Resident found on floor its. Resident stated he was wheelchair and his legs ury noted, no c/o pain, MD and family its reminded to ask for ferring self." Ince Assessment and its earlier in the form that it is a serious properties of above the agrees as appropriate to be no. Date of Review its earlier in the form that is a serious properties and its properties of the properti					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(.	X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE COMPL		
ANDILAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		- 1	A. BUILD	ING	00		06/15/2	
		1.57.12	E	B. WING	STREET A	DDRESS, CITY, STA	TE ZID CODE	55.10/2	
NAME OF F	PROVIDER OR SUPPLIER	t.		- 1		TIPTON ST	ale, zip code		
COVERE	ED BRIDGE HEALTH	H CAMPUS				UR, IN47274			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			ID	DROVIDED'S D	LAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PF	REFIX	(EACH CORRECTIV CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		'	TAG	DEF	ICIENCY)		DATE
	1	n, dated 3/25/11, was							
	updated on 4/7/1								
	intervention of "Res to be up in w/c for meals and encourage res to go to DR for								
	meals."								
	The Murgon Moto	es, dated 4/27/11 at 4:30							
		"Summoned to res							
		per CNA noted res on							
		bed and recliner states							
		from w/c to recliner							
		ned L [left] but turned R							
		s noted moves all							
		foredenies any pain							
		ad no red or open areas.							
		oor to recliner with 2							
	staff"								
		ance Assessment and							
	1	ed 4/27/11, indicated,							
	1	odate- teach w/c safety.							
	_ ^	linary Team] review- IDT							
	l '	prevention update agrees							
		maximize safety- No.							
		4/28/11, IDT review							
		following change to							
		te: Velcro belt without							
		res to ask for assist use							
	call light when tr	ansiering							
	The fall care plan	n, dated 3/25/11, was							
	updated on 4/27/								
	_	Velcro belt without alarm							
		use call light/request							
FORM CMS-2	2567(02-99) Previous Versio		 ZH1	 Γ711	Facility I	D: 003342	If continuation sl	neet Pa	ge 31 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER)			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		A. BUIL		00	06/15/2011
		1557 12	B. WING		PRESIDENCE CONTROL CON	00/13/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 'TIPTON ST	
COVERE	ED BRIDGE HEALTH	H CAMPUS			DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	assist when trans	ferring."				
	The Nurses Note	s, dated 5/5/11 at 3:30				
	P.M., indicated, "Summoned to res room					
	per CNA res on f	loor on buttocks in front				
	of toilet with bac	k leaning against toilet.				
	States missed w/	c and sat self to floor				
	softlyno red or	open areas denies pain.				
	assisted to w/c pe	er two staff"				
	A Fall Circumsta	nce Assessment and				
	intervention, date	ed 5/5/11, indicated,				
	"Prevention Up	odate- Alarming seat belt.				
	IDT [Interdiscipl	inary Team] review- IDT				
	review of above	prevention update agrees				
	as appropriate to	maximize safety- Yes.				
	Date of Review 5	5/6/11"				
	_	n, dated 3/25/11, was				
	updated on 5/5/1					
		self releasing velcro				
		t staff of unassisted				
	transfers."					
	1	lated 5/6/11, indicated,				
		nfusedResident has				
	1 *	Resident has history of				
	_	er] of alls in last 3				
		ion of falls- In room.				
		ituational information- Pt				
	[patient] self transferring instead of using					
	light for assistant	ce"				
	TI N N 1 . 15/6/11 200					
	The Nurses Note	s, dated 5/6/11 at 9:00				

003342

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155712	B. WIN			06/15/20)11
NAME OF I	DROVIDED OD CUDDI IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	PROVIDER OR SUPPLIER			1675 W	TIPTON ST		
	ED BRIDGE HEALTI				DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEI ICIENCI)	+	DATE
	l ' '	"After investigation of					
		on 5/5/11, found that res					
		ng to use call light when					
	removing velcro seat belt. Continues to transfer per self, and has difficulty recalling where w/c is placed and is legally blind. Will place alarm to self						
	1	belt as enabler to alert					
	staff of unassiste	d transfers"					
	The Nurses Notes, dated 5/8/11 at 3:25						
	A.M., indicated,	"Res fell at approx					
	[approximately]	3 AM. CNA summoned					
	nurse to room (n	umber). Res lying in floor					
	on his R side wit	h feet out beneath					
	recliner. Draw sh	neet beneath res buttocks					
	and blankets wer	re at foot of bed. Res					
	states "I was tryi	ng to sit up and slipped					
	off of bed into flo						
	pain/discomfort.	no red areas or injuries					
	_	back into bed via ii [two]					
		le rail] down to remind					
		ht to transfer into recliner					
	ľ	alized understanding of					
		nes to stay in bed at this x					
	[time]"	,					
	A Fall Circumsta	ince Assessment and					
	intervention, dated 5/8/11, indicated,						
	"Prevention Update- 1/2 SR to remind						
	res to use call light to assist with transfers.						
	IDT [Interdisciplinary Team] review- IDT						
		prevention update agrees					
	l '	maximize safety- No.					
	appropriate to				<u>L</u>		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 06/15/20	ETED	
	PROVIDER OR SUPPLIES		P: William	STREET A	DDRESS, CITY, STATE, ZIP CODE TIPTON ST		
COVERE	ED BRIDGE HEALT	H CAMPUS		SEYMO	UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Date of Review 5/9/11, IDT review recommends the following change to prevention update: alarming floor mat while in bed or recliner, will obtain UAC & S [urinalysis with culture and sensitivity] next lab day"						
	The fall care plan, dated 3/25/11, was updated on 5/8/11, to include the intervention of "alarming floor mat while in bed or recliner UA C & S." 4. Resident #39 was identified by RN #1 on 6/13/11 at 9:30 A.M. as having had falls, cognitively impaired, and incontinent of urine. The resident was observed at the time of the tour to be in bed with a full mattress beside the bed. On 6/13/11 at 3:30 p.m. Resident #39 was observed in the low bed. No mattress was observed down on the floor beside him. Visitors were also observed in the						
	observed in his l observed on the alarm on the bed connected to the wheelchair was seat belt not late back of the chair wheelchair was	sitting in the room, the hed and the alarm on the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZHT711

Facility ID:

003342

If continuation sheet Page 34 of 51

STATEMENT OF DEFICIENCIES				2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. 1	BUILDING	00				
		155712	В. У	WING			06/15/2	UTT	
NAME OF I	PROVIDER OR SUPPLIEF			1	DDRESS, CITY, STA	ATE, ZIP CODE			
					TIPTON ST				
COVERE	ED BRIDGE HEALT	H CAMPUS		SEYMO	UR, IN47274				
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)	
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEF	FICIENCY)		DATE	
		C D :1							
	The charge nurse for Resident #39, LPN #1, was notified at 1:35 P.m. of the								
	1	bed. She indicated she							
		no put him to bed. CNA							
		he same time she was the							
	_	esident #39's hall and she							
	had not placed h	im in bed. LPN #1							
	indicated maybe	therapy had placed him							
	in bed.								
	Resident #39's clinical record was								
	reviewed on 6/13	3/11 at 11:50 p.m.							
	Diagnoses include	ded, but were not limited							
	to: "Dizziness ar	nd pneumonia."							
	The most recent	MDS (Minimum Data							
	Set) assessment,	dated 3/29/11, an							
		sment, indicated the							
		d assistance with transfers							
		had fallen in the past 2 to							
		vas moderately cognitively							
	impaired.								
	The care plan for	r falls, dated 4/1/11 and							
		6/11, included a problem							
	ı ^ ~	for injury related to							
		nd potential of falls,							
	I -	-							
	related to disease process/condition,								
	dizziness, depression, functional problem,								
	decreased mobility, instability, use of assistance devices, wheelchair, walker								
	with assist." The goal was the resident								
	will have reduce	ed risk of fall related							
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	ZHT7	11 Facility I	D: 003342	If continuation sh	eet Pa	ge 35 of 51	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712		MULTIPLE CONSTRUCTION UILDING UING (X3) DATE SURVEY COMPLETED 06/15/2011		ETED	
NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN47274				
				SETIVIO	JUR, IN47274		(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE CONCOSS-REFERENCED TO THE APPROPRIATE	
	injury by utilizing Interventions in MD/responsible effects of any dra disturbance, orthogonal weakness, sedation mental status (if Report to MD and associated was and associated was and associated was and associated was and in the Intervention of the Intervention o	g fall precautions. cluded: "report falls to party," "monitor for side ug that can cause gait costatic hypotension, on, vertigo, change in noted, report to RN), by negative side effects with residents medication ironmental adaptions: d, half rails as enabler, h, adequate glare free e of clutter, use of adaptive cane with assist, and resident and reinforce s, lock breaks on bed, transferring, educate st assistance prior to repriate footwear, escort cams, safety measures to ditional approaches: bed, 4/18/11-educate staff by assist with showers, cation on requesting ys of ribs, non skid 1- bed/chair alarm, lasses are within reach, sition, 6/2/11-self alarm bed as enabler, st wall.		IAG			DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZHT711

Facility ID:

003342

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		155712	B. WIN			06/15/20	11
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1675 W	TIPTON ST		
	ED BRIDGE HEALTH	H CAMPUS			OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	гЕ	COMPLETION
TAG		·	+	TAG	DEFICIENC!)		DATE
	forms indicated t	he following:					
		15 p.m., the resident had					
		ver, staff were educated to					
	stay with him du	ring the shower. Staff					
	had indicated he	had asked them to give					
	him privacy.						
	"5/18/11 at 7 p.m	n. CNA walking by room					
	_	ident down on one knee,					
		and a/c (air conditioner)					
		es when stated he thought					
	1 *	ok and was looking for it					
		Il, CNA went to get a					
	· ·	e assessed res she noted					
		back 13 cm by 1 cm, 6					
	I -	m by .8 cm and a skin					
		2 by 2 cm, nurses then					
	_	had fallen when he					
	· ·	on't tell anyone' Nurse					
	*	that when a fall occurs					
	she needs to know	w." The fall					
	circumstance/ass	essment and intervention					
	form, dated 5/18/	/11, indicated the resident					
	· ·	ill fitting footwear on,					
		on update included: non					
	_	d remind to ask for					
	assisted from star						
	 "5/20/11 2·20 A	M. resident put on call					
		nded to find resident					
	• •	side beside his bed with					
		feet (upright position)					
	Both legs flexed	at his knees and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/15/2 (ETED	
		1007 12	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF	PROVIDER OR SUPPLIE	3			TIPTON ST		
COVER	ED BRIDGE HEALT	H CAMPUS			DUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAG	+	reight on his left elbow.	-	IAG	,		DATE
	^^	iies hitting his head or					
	1 -	snessassisted to bed					
		bed and wheelchair alarm					
	ordered"	oca ana wheelenan alarm					
		stance/assessment and					
		n, dated 5/20/11,					
	1	vention update-bed an or					
	chair alarm.	, , , , , , , , , , , , , , , , , , ,					
	"5/28/11 12:15 A	A.M. Resident bed alarm					
	sounded, staff ti	mes 2 responded to find					
	resident on his le	eft side on the floor beside					
	his bed. His kne	es were both flexed and					
	he was leaning of	on his left elbow. Area					
	was free of clutt	er. non skid socks in					
	place. Res was n	ot wearing his eyeglasses.					
	His call light wa	s in easy reach on his					
	right side. Light	ing in room was					
	appropriate for t	his time of night semidark					
	with the hall ligh	nt onlifted times 2 staff					
	back to bed. Not	ed 1.3 cm linear skin tear					
		ed alarm in place"					
		tance/assessment and					
		n, dated 5/28/11, at 12:15					
	1	"ensure glasses are within					
	reach"						
	"5/28/11 5:00 A	.M. CNA called writer to					
	room, resident o	n the floor on both knees					
	1 '	rith elbows on mattress					
		ad removed his oxygen					
	1	rm had not sounded					
	secondary reside	ent elbow being on the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155712	A. BUIL	DING	00	COMPL 06/15/2	
		1557 12	B. WING			00/15/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ' TIPTON ST		
COVERE	ED BRIDGE HEALTH	H CAMPUS			DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	pad. Assisted bad	ck to bed times 2, call					
	l *	ed placed in lowest					
	position which w	ould not cause wheels to					
	_	t stated he got down on					
	his knees to put '	the pills back in the					
	bottle' no pills pr	esent" The fall					
	circumstance/ass	essment and intervention					
	form, dated 5/28/	/11 at 5 a.m. indicated a					
	medication revie	w would be done.					
	_	es fell from wheelchair					
	"	oor resident denies pain					
		top of head alarm to					
		dingassisted back to					
		assist of 2placed at					
	nurses station"						
		essment and intervention					
		/11 at 7 p.m. indicated for					
		e: bedside mat, low bed					
	and placed at nur	rses desk to monitor."					
	W 6 / 2 / 1 1 4 4 0	0 1 0 .					
	1	res found on floor in					
		wheelchair stated 'I was					
	, , , ,	n on the floor to play					
		boys' res assisted to to					
		assist of 2" The fall					
		essment and intervention					
		1 at 4:40 p.m., indicated,					
	for prevention up wheelchair."	ouait to aujust					
	wheelchan.						
	 "6/2/11 6:15 n m	. res alarm sounding res					
	on floor res alert	_					
		esting alarming seat belt					
	Comusionreque	sing alanning scal ocit					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S COMPL		
		155712	B. WIN			06/15/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
COVEDE	ED BRIDGE HEALTH	J CAMDUS		1	TIPTON ST DUR, IN47274		
				l	JUR, IN47274		715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	to wheelchairpl	laced at nurses station 1					
	on 1" The fall	circumstance/assessment					
	and intervention	form, dated 6/2/11 at					
		ated prevention update,					
	"alarming seat be						
		essment and intervention					
		e and time, indicated for					
	prevention updat	e, "alarming seat belt."					
	"6/2/11 of 2:20 A	.M. alarm sounded and					
		om to find res standing at					
		hold on to the door					
		ging back and forth,					
	_	it to take hold of resident					
		tail of his sweatshirt					
		the floor on his right					
		rned to knees and pulled					
	himself up on dre	essernoted skin tear to					
	right forearm pos	sterior aspect" The fall					
		essment and intervention					
	,	e and time, indicated for					
ı	prevention updat	e "bed against wall."					
	2.1.45(.)(2)						
	3.1-45(a)(2)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/15/2011
	PROVIDER OR SUPPLIER		1675 W	ADDRESS, CITY, STATE, ZIP CODE TIPTON ST OUR, IN47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug we (including duplicate duration; or without without adequate in the presence of accordinate the dose of discontinued; or areasons above. Based on a compresident, the facility residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to discord and the discordinate without adequate in the discordinate without adequate that Alprazolam was administered individualized plenon-pharmacologion the resident's residents reviewed sample of 14. Refindings include Resident #28 was	gical interventions based symptoms, for 1 of 12 ed for medications in the esident #28	F0329	F 329 Resident #28 suffered no ill effetom the alleged deficient practice. Completion Date 7-13-2011 All residents have the potential affected by the alleged deficient practice therefore through syste changes stated below the camputensure medications are administ with adequate indications for us Completion Date 7-13-2011 An in-service was provided to nursing staff concerning non-pharmacological intervention	to be t mic as will tered ee.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZHT711

Facility ID: 003342

If continuation sheet Page 41 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		(X2) MULTIPLE CO	00	(X3) DATE COME 06/15/	LETED	
	PROVIDER OR SUPPLIER		1675 W	ADDRESS, CITY, STATE, ZII I TIPTON ST DUR, IN47274	_	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	at 10:00 A.M. as requiring a Hoye being bedfast. T lying in bed at the Resident #28's characteristic reviewed on 6/14 MDS (Minimum dated 3/18/11, in severely cognitive altered level of cognitive and antipolated 6/7/11, in appearance as ever anxiety and antipolated for level level of cognitive and new environ and new environ linterventions in cognitive and new environ linterventions in cognitive and order see curred Physician orders an order, which we have a supplied to the second level leve	cognitively impaired, or lift for transfers and the resident was observed to time of the tour. inical record was the part of the tour. In country in the part of th	TAG	for residents with be plans. Systemic char the care plan for resibehaviors will be key the resident's specifi administration sheet. Completion Date 7-DHS/designee will programmer 2 random residents the administration of week x one month the one month then week forwarded to QA contact x 6 months and quar for review and furthe suggestions/commer Completion Date 7-	chaviors and care nge is a copy of idents with active pt in the front of ic medication. 13-2011 Derform audits of o assure all interventions empted prior to f medication 5x nen 3x a week x kly with results mmittee monthly terly thereafter er nts	DATE
	tablet per peg [ga hours as needed	astrostomy] tube every 6 for anxiety."				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155712	B. WIN			06/15/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		1675 W	TIPTON ST		
	ED BRIDGE HEALT				OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
		· · · · · · · · · · · · · · · · · · ·					
		inistration Records for					
	1 -	ane 1 to 13, 2011, and the					
	PRN Medication	•					
		prazolam was given on					
	1	tes: 5/4/11 7:30 p.m.,					
		6/11 7 p.m., 5/8/11 8 a.m.					
		1 8 a.m. and 8 p.m.,					
	5/11/11 7 p.m., 5	5/12/11 7 p.m., 5/14/11 7					
	p.m., 5/15/11 7 p	o.m., 5/21/11 11 p.m.,					
	5/23/11 1 a.m. 9	p.m., 6/3/11 11 p.m.,					
	6/5/11 a.m., and	6/13/11 7 a.m. The PRN					
	Medication Trac	king Form indicated the					
	reason given for	each dose was "2." The					
	_	cated "2" was anxiety					
	(pacing, hand wi	•					
		nxiety, etc.). There were					
	1 ^	ns documented as tried					
		eation was given. The					
		ns were a combination of					
		2-bedrest, 5-diversion,					
	10-social service						
		15-position for comfort,					
	and 13-one on or	*					
	and 13-one on or	no unio.					
	Nurses Notes da	ted from 4/23 through					
		any documentation of					
	· ·	the resident was doing					
	I -	_					
	prior to the administration of the Alprazolam. The Skilled Nursing						
		Data Collection Forms,					
		1 through 6/13/11, did					
	1	•					
	1	documentation under the					
	box labeled "Mo	od and behavior, check					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZHT711

Facility ID:

003342

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155712		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/15/20	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	{		1	TIPTON ST		
COVERE	ED BRIDGE HEALT	H CAMPUS		SEYMO	OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE.	COMPLETION DATE
1710		Areas to check included,		1/10			DATE
	1 1 1	ited to: "Trouble falling					
		o, fidgeting/restless,					
	lethargic, behavi	or interfere with social					
	interactions, disr	rupt environment, resident					
	rejects care"						
	The Social Servi	ce Progress Notes,					
		dated 3/12/11 and 5/4/11.					
		y included: "resident					
		n .25 mg every 6 hours					
	prn (as needed)	for anxiety." The 5/4/11					
	entry indicated the	he resident was adjusting					
	to new room "res	s voices no concerns and					
	says yes to being	g pleased with new room."					
		otes concerning the					
	resident being ar	nxious.					
	During interview	with RN #1 on 6/14/11					
	~	he indicated the facility					
	used a behavior	book for residents with					
	behaviors. She i	ndicated Resident #28					
	was not included	I in the book, and that					
	Social Services	created the plans in the					
	book.						
	During interview	with the Social Service					
		4/11 at 10:05 A.M. she					
	· ·	ident did not currently					
		ne indicated she was not					
	*	giving the as needed					
		hat the resident's					
	symptoms were.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII		00	COMPI	LETED	
		155712	B. WIN	_		06/15/2	:011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	D BRIDGE HEALTH	H CAMPUS		SEYMO	OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		with LPN #3 on 6/14/11	+				52
	-	indicated she worked					
	-	had administered the					
	_	ral times in May 2011.					
	-	resident was restless, on					
		eral times, would not use					
	_	on board and staff were					
	unable to figure of	out what the resident					
	wanted. She indi						
	resident was muc	ch better at this time and					
	she had not giver	n the drug since mid May.					
	3.1-48(a)(6)						
R0000							
KUUUU							
	were cited in account 16.2-5.	ate residential findings ordance with 410 IAC		000	The submission of this Plan of Correction does not indicate admission by Covered Bridge Health Campus that the findi and allegations contained he are accurate and true representations of the quality care and services provided to residents of Covered Bridge Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services residents in an economic and efficient manner. The facility hereby maintains it is in	an e ngs rein of to the to its	
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: Z	ZHT711	Facility I	provide legally and medically necessary care and services residents in an economic and efficient manner. The facility hereby maintains it is in	to its	ge 45 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155712	A. BUIL	DING	00	06/15/2	
		100712	B. WIN			00/13/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
COVERE	D BRIDGE HEALTH	H CAMPUS			UR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG		J	DATE
R0240	activities of daily li	and assistance with ving, shall be provided dual needs and preferences.			substantial compliance with trequirements of participation comprehensive health care facilities (for Title 18/19 programs). To this end, this P of Correction shall serve as to credible allegation of complia with all state and federal requirements governing the management of this facility. If thus submitted as a matter of statue only.	for rlan he ance t is	
	Based on observation interview, the factor interview in a state of the factor interview. The factor interview is a state of the factor interview in a state of the factor interview. The factor interview is a state of the factor interview in a state of the factor interview. The factor interview is a state of the factor interview in a state of the factor interview. The factor interview is a state of the factor interview in a state of the factor in a state of the factor interview in a state of the factor interview in a state of the factor interview in a state of the factor in a state of th	ation, record review, and cility failed to insure vided proper incontinence esidents reviewed for sample of 8 (Resident int #105)	R0	240	R 240 Resident #101 and #105 suffere ill effects in alleged deficient practice. Completion Date 7-13-2011 All incontinent residents have the potential to be affected by the addeficient practice and through changes in provision of care and in-servicing will prevent the recurrence of the deficient practice. Completion Date 7-13-2011 An in-service was completed for nursing staff concerning resident receiving incontinent care to happroper procedure followed. Systichange includes all caregivers to complete return demonstration of incontinent care skills now, and yearly thereafter. Completion Date 7-13-2011	ne Illeged I tice. r tts ve ttemic o of all	07/13/2011
		lent #2 urinated a large			DHS/designee will perform aud	dits of	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155712		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	COM	TE SURVEY IPLETED 5/2011	
	PROVIDER OR SUPPLIER ED BRIDGE HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	amount in the coobserved to hand toilet paper and to bottom. CNA #2 stand at a pull up commode. The relative reddened in dripping urine frow was observed to bottom nor provisincontinence care. Review of Reside on 06/13/11 at 1 Resident #101 has included, but were dementia, lumbar obstructive pulm osteoporosis. A nurse's note, dap.m. indicated, "(culture & sensitic (antibiotic medicurinary tract infer (milligrams) (to days. Pharmacy obtained2 dose (Emergency Druges)	the resident a piece of the resident wiped her assisted the resident to bar beside the resident was observed to the resident's deany type of the resident to the resid			3 random residents who are incontinent for compliance proper procedure 5x week x month then 3x a week x on then weekly with results fo QA committee monthly x 6 and quarterly thereafter for and further suggestions/cor Completion Date 7-13-201	with one emonth warded to months review nment	
ı	l ′	owth after 24 (hours).					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SUI COMPLET		
AND PLAN	OF CORRECTION	155712	A. BUILI		00	06/15/201	
		1007 12	B. WING		DDDEGG CITY CTATE ZIR CODE	00/10/201	'
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COVERE	ED BRIDGE HEALTH	H CAMPUS			DUR, IN47274		
		TATEMENT OF DEFICIENCIES		ID	.,		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Results faxed to	(physician)."	1				
		u ,					
	2. During initial tour of the environment						
	_	0:00 a.m. with QMA #1					
		#105 was identified as					
	*	impaired, incontinent,					
		assistance from staff for					
	toileting.						
	On 06/13/11 at 1	:05 p.m., CNA #2 was					
	observed to toile	t Resident #105. The					
	resident was obse	erved to pull her own					
		remove a wet brief. The					
	resident indicated	d "I'm taking this down."					
		erved to use 1 cleansing					
		e the resident's bottom					
	from front to bac						
	Review of Reside	ent #105's clinical record					
	on 06/14/11 at 1:	00 p.m. indicated:					
	Resident #105 ha	nd diagnoses which					
	included, but we	re not limited to,					
	dementia and dia	betes mellitus.					
	A physician's tele	ephone order, dated					
	05/14/11, indicat	ed, "Urine C&S (Culture					
	& Sensitivity) - (• `					
	medication often	used to treat urinary tract					
	infections) 250 (1	milligrams) (twice daily					
	times 7 days).						
	A service plan, d	ated 06/09/11, indicated:					
	Resident #105 w	as totally dependent on					

Facility ID:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	A. BUILD		OO	(X3) DATE S COMPL 06/15/20	LETED	
NAME OF PROVIDER OR SUPPLIER			B. WING GO/13/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST					
COVERE	D BRIDGE HEALTI	H CAMPUS		SEYMOU	JR, IN47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	staff for hygiene	and was incontinent.						
	05/16/11, indicat Leukocytes (bloo report indicated t	alysis report, dated ed Resident #105 had 3+ od cells) in her urine. The he normal range for ine was "negative."						
	Care for the Inco Guideline" was p 06/14/11 at 12:23 documentation in provide inconting skin from being of periods of urine a Residents may be cloths, wet wipes wash cloths or do peri-cleanser sho the cloths/wipes. not be needed if	endicated, "Purpose: To ence care that will keep exposed to prolonged and feces. Procedure -1. e cleaned using wash s or dry wipes. 2. If y wipes are used uld be used to moisten 3. Peri-cleanser will using pre-moistened wet ded to remove excessive						
R0246	(6) PRN medication a qualified medical authorization by a The QMA must require authorization for emedication. All comphysician not on the authorization to accommented in the time and date	ins may be administered by tion aide (QMA) only upon licensed nurse or physician. Derive appropriate ach administration of a PRN intacts with a nurse or the premises for liminister PRNs shall be a nursing notes indicating	R02	46	R 246		07/13/2011	

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		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION				UILDING 00		COMPLETED	
	155712		B. WIN	IG		06/15/2011	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	FROVIDER OR SUFFLIER			1675 W	TIPTON ST		
	ED BRIDGE HEALTI			SEYMO	DUR, IN47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		1
TAG			-	TAG	DEFICIENCY)	DATE	_
	1	ensure unlicensed staff			Res # 101 suffered no ill effects	. from	
	requested permission from licensed staff and documented according to facility guidelines on PRN (as needed) medications for 1 of 8 residents reviewed for medications in a sample of 8. (Resident #101)				the alleged deficient practice.	s from	
					the aneged deficient practice.		
					Completion Date 7-13-2011		
					·		
					All residents have the potential		
					affected by the alleged deficien		
					practice and through alterations	in	
	Findings include	-		processes and in-servicing will			
	i mamgs merade	•			ensure the campus ensures unlicensed staff request permiss	vion	
	Davious of Dagid	ent #101's clinical record			from licensed staff and docume		
					according to campus guidelines		
	on 06/13/11 at 12:00 p.m. indicated the				concerning prn medication		
	following:				administration.		
					Completion Date 7-13-2011		
	Resident #101 had diagnoses which						
	included, but we	-		Nursing staff have been in somi		. ,	
	dementia, chroni	c obstructive pulmonary			Nursing staff have been in-serv regarding the procedure for nor		
	disease, osteopor	osis, and lumbar			licensed staff to administer prn		
	stenosis.				medication. Systemic change is	non	
					licensed staff will request perm		
	A Medication Re	ecord for May, 2011			to administer a prn medication		
		nt #101 received (1)			the nurse will cosign the prn log	3	
		oap 5/325 on 05/16/11 at			Completion Date 7-13-2011		
	6:45 a.m. The Medication Record						
					DHS/ designee will review 3 ra	ndom	
	indicated the medication was given to the resident by QMA (Qualified Medication Assistant) #1. A "PRN (as needed) Medication Tracking" record for May, 2011 indicated Hydrocodone/Apap 5/325				resident's prn medication log to		
					assure compliance 5x a week for		
					month then 3x a week for a mor		
					then weekly with results forwar		
					QA committee monthly x 6 mo		
	was given to resident #101 by QMA #1 on 05/16/11 at 6:45 a.m.				and quarterly thereafter for revi and further suggestions/comme		
					Completion Date 7-13-2011	ins	
					Simpletion Date / 10 2011		
	A Medication Re	ecord for April, 2011					
	indicated Reside	nt #101 received (1)					

Facility ID:

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/15/2011		
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE			
COVERED BRIDGE HEALTH CAMPUS			1675 W TIPTON ST SEYMOUR, IN47274					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Έ	(X5) COMPLETION DATE	
TAG	Hydrocodone/Ap 8:10 a.m. A "PR record for April, Hydrocodone/Ap Resident #101 b 8:10 a.m. Resident #101's documentation s contacted a licen giving the PRN n Interview of the Nursing) on 06/1 indicated QMA's licensed staff pri medications. Th nursing staff wor QMA's giving Pi	pap 5/325 on 04/28/11 at N Medication Tracking" 2011 also indicated pap 5/325 was given to by QMA #1 on 04/28/11 at clinical record lacked apporting QMA #1 sed nursing staff prior to medication. DON (Director of 4/11 at 9:10 a.m. as had not been calling or to administering PRN to DON indicated alluld be inserviced on RN medications.		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
	Guidelines Medi and dated Decen by the DON on (documentation in "Administer prev medication only obtained, the QN following: (A) I	itled "Assisted Living cation Administration" her 2010, was provided 06/14/11 at 9:10 a.m. The indicated, QMA's must viously ordered (PRN) if authorization is MA must do the Document in the resident is indicating the need for						